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Overview of the Home Health Survey Process

Wednesday, June 17, 2015

Preparing for Federal Onsite Survey/Inspections

Presenters:
Deb Jaquette & Kristal Foster
Rick Brummette, RN; Darlene Fuller, RN; Kellie Edwards, RN;
Linda Harkness RNC; Linda VanGansbeke, RN; Deirdre Laviolette, RN:
Health Care Surveyors, BCHS

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State Organization Structure

Bureau of Community & Health Systems (BCHS)

Effective Date June 2015

- State Licensing of Health Facilities, Agencies and Programs
- Federal Certification of Providers and Suppliers on Behalf of the Centers for Medicare and Medicaid Services (CMS)
- State Licensing of Child Care Centers
- State Licensing of Adult Foster Care/Homes for the Aged
- Construction Permits of State Licensed Health Facilities

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Michigan Covered Providers

(As of April 2015)

No. of Providers	Type
10,058	Child Care Centers
8,348	Clinical Laboratory Services
4,291	Adult Foster Care Homes
1,284	Substance Use Disorder Programs
646	**Home Health Agencies**
452	Nursing Homes/LTC Facilities
218	Homes for the Aged
197	Dialysis Centers (ESRD)
169	Hospitals
162	Outpatient Physical Therapy (OPT)/Speech Pathology
160	Rural Health Clinics (RHC)
133	Freestanding Surgical Outpatient Facilities/ASC
131	Hospice Agencies
59	Inpatient Psychiatric Hospitals/Units
30	Psychiatric Partial Hospitalization Programs
18	Hospice Residences
9	Organ Transplant Facilities
9	Portable X-Ray Providers
6	Comprehensive Outpatient Rehab Facilities (CORF)

** Some federal oversight for organ procurement organizations (1) and federally qualified health centers (196).*

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BCHS State/Federal Oversight of Covered Providers

State	Federal	Type
YES	YES	Child Care Centers
YES	YES	Clinical Laboratory Services
YES	NO	Adult Foster Care Homes
YES	NO	Substance Used Disorder Programs
NO	**YES**	**Home Health Agencies**
YES	YES	Nursing Homes/LTC Facilities
YES	NO	Homes for the Aged
NO	YES	Dialysis Centers (ESRD)
YES	YES	Hospitals
NO	YES	Outpatient Physical Therapy (OPT)/Speech Pathology
NO	YES	Rural Health Clinics (RHC)
YES	YES	Freestanding Surgical Outpatient Facilities/ASC
YES	YES	Hospice Agencies
YES	YES	Inpatient Psychiatric Hospitals/Units
YES	NO	Psychiatric Partial Hospitalization Programs
YES	YES	Hospice Residences
NO	YES	Organ Transplant Facilities
NO	YES	Portable X-Ray Providers
NO	YES	Comprehensive Outpatient Rehab Facilities (CORF)

** Some federal oversight for OPO and FQHC.*

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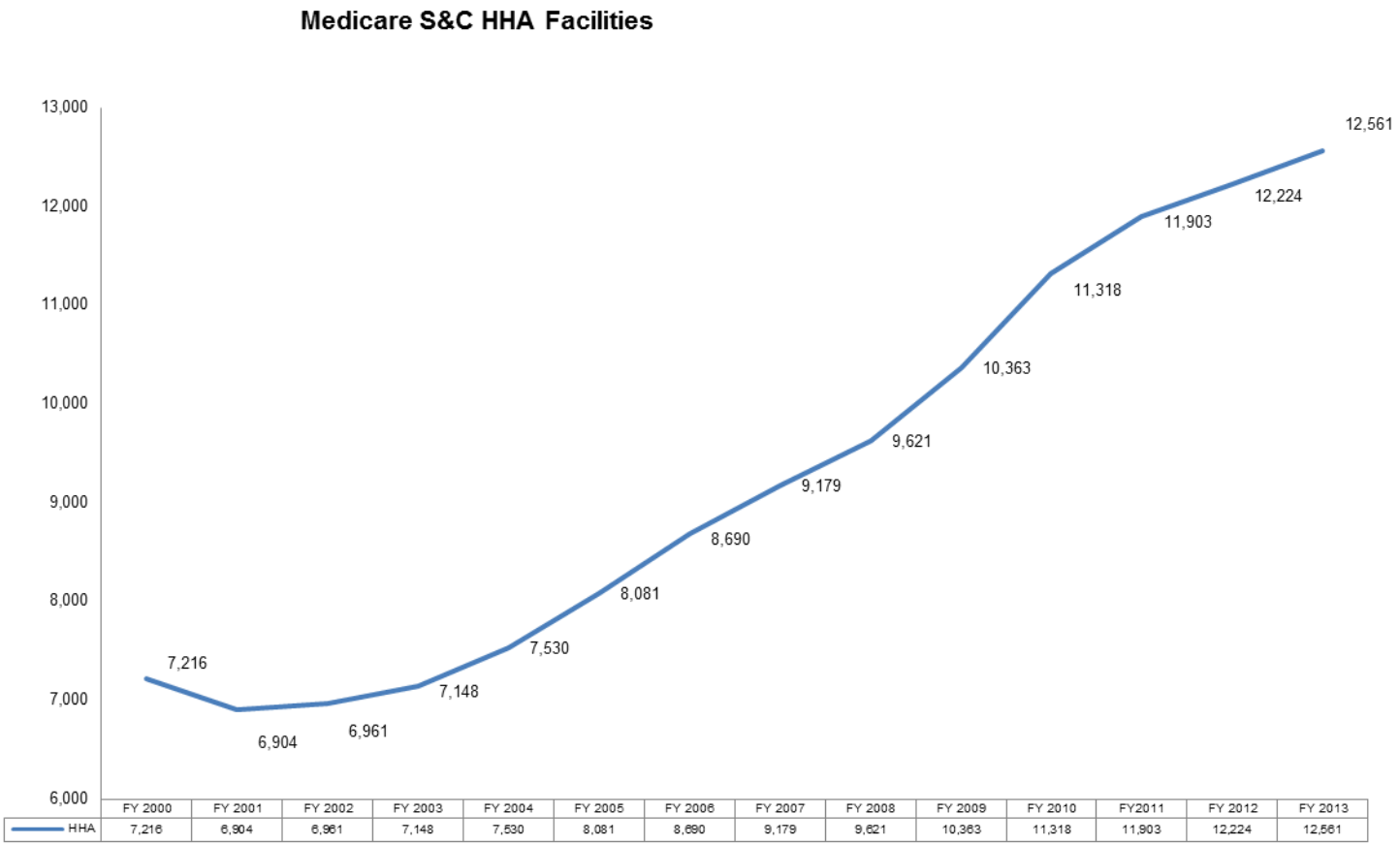
Growth in Home Health Agencies



	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY2011	FY 2012	FY 2013
HHA	7,216	6,904	6,961	7,148	7,530	8,081	8,690	9,179	9,621	10,363	11,318	11,903	12,224	12,561

80% Growth since 2002 to 2013.

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Regulatory Overview

Rick Brummette RN, BSN, Manager
Specialized Healthcare Services Section

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Regulatory Overview

State Agency (SA) Oversight Activities:

- Outcome & Assessment Information Set (OASIS) – Maintains the system that OASIS data is submitted to.
- Independent informal dispute resolution (IDR)/alternative sanctions (civil monetary penalties, suspension of payment, temporary manager, directed plan of correction) – July 2014
- Complaint: intake, triage, and investigation.
- CHOW, Branch Site, and Change of information applications.
- Temporary moratoria on new home health agencies and sub-units in SE Michigan until July 2015

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Regulatory Overview

Moratoria Area:

- Detroit Metropolitan area including: Macomb, Oakland, Washtenaw, Wayne and Monroe Counties.
- Has been renewed every 6 months since January 30 2014.
- Halts the enrollment of:
  - new HHA's,
  - HHA branch locations
- HHA's are also not permitted to move from the Moratoria area or move to the Moratoria area.

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HHA's vs Non-Certified HHA's

Kellie Edwards, RN
Health Care Surveyor

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HHA's vs Non-Certified HHA's

What is the difference between a Certified and Non-certified HHA?

- No State licensing required.
- Medicare Certified HHA's aka Skilled Services(SN, PT, OT, ST, MSW, HHA, RD) that are medically necessary, short term, intermittent, and the patient is home bound.
- Non-certified HHA's aka Private duty, Home Help provider, Chore service etc.

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Federal Certification Process

- Provider submits enrollment application (855A) to fiscal intermediary (FI)/Medicare Administrative Contractor (MAC) – *National Government Services* (NGS)
- Provider submits Medicare paperwork to LARA including OMB 0990-0243, HHS-690, CMS-1561, CMS-1572A, BHCS-HFD-150, BHCS-HFD-803 (branch site application)
- FI/MAC reviews application and makes recommendation to approve or deny to State Agency (LARA) with copy to CMS Regional Office (RO)
- Approved accreditation organization (AO) conducts initial survey to determine compliance with federal Conditions of Participation and makes recommendation to approve or deny to RO
- RO makes the final decision regarding eligibility and, if approved, provider signs provider agreement

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General Survey info

- Initial Certification Survey: Certification must be done by an Accrediting Organization.
- Re-certification Survey: occurs every 36.9 months or sooner.
- All surveys are an evaluation of the COP's
- Complaint Surveys:-must have Region V permission before investigating (Deemed Agencies)

  -Are focused to the COP most related to the complaint.

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Preparing for an HHA Survey

Linda VanGansbeke RN, BSN
Health Care Surveyor

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Preparing for an HHA Survey

- Organization Chart.
- Complete Home Health Agency Survey/ Deficiencies Report (CMS1572).
- Admission Packet
- List of unduplicated admissions.
- A List of current patients.
- A list of staff both directly employed and contractual with their respective disciplines and hire dates.
- A list of contracts utilized by the agency.

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Preparing for an HHA Survey

- Provide a home visit schedule.
- Policy & Procedure manuals.
- Copy of your CLIA Waiver.
- Depending on how the Survey progresses, we may also have to ask to review:**
- Governing Body and Professional Committee Meeting minutes.
- Annual Evaluation, Budget, Bylaws, & Articles of Incorporation.
- Quarterly clinical record review data.

Preparing for an HHA Survey

(cont)

- Personnel records for professional and contract staff.
- List of in-services for professional staff.
- Home Health Aide personnel records.

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Preparing for an HHA Survey

- EMR's:
- Develop policies, procedures and tools for giving access to surveyors.
- Designate a person to work with the Survey Team with clinical and computer knowledge.
- Provide EMR instructions and temporary user ID's with passwords.
- Make computers available.
- Be able to print any part of the record needed by the Survey Team.

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Top 5 HHA Deficiencies

Darlene Fuller, RN, BSN

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Deficiencies Cited (Conditions/Standards)

Top 5 Deficiencies Cited for Michigan Home Health Agencies
§484.18(a)/G0159 Standard: Plan of Care: The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.
§484.55(c)/G0337 Standard: Drug Regimen Review: The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
§484.36(c)(1)/G0224 Standard: Assignment: The Home Health Aide is assigned to a specific patient by the Registered Nurse. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.
§484.30(a)/G0176 Standard: Duties of the Registered Nurse: The HHA furnishes skilled nursing services by or under the supervision of a registered nurse; and prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.
§484.30/G0170 Condition: Skilled Nursing: The HHA furnishes skilled nursing services by or under the supervision of a registered nurse; in accordance with the plan of care.

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How to Prepare Your Plan of Correction if Needed

Linda Harkness, MSN, BSN, RNC
Health Care Surveyor

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Begin with the Exit Conference

- The Purpose of the exit conference is to informally communicate preliminary survey team findings and provide an opportunity for the interchange of information.
- The surveyor will not cite specific Tag #s during the exit conference.
- You CAN start working on your POC beginning on the survey exit date.

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The Plan of Correction

Official findings are presented in writing on Form CMS-2567 and will be forwarded to the provider within **10 working days** from the exit date.

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Acceptable Plan of Correction

The provider will have **10 Calendar days** to submit a Plan of Correction to the State Agency.

- Additional Pages may be attached.
- Form CMS-2567 is not a fillable form-Provider writes corrections in the Center Column of the CMS-2567.
- The Administrator must sign and date at the bottom of page 1 of the CMS-2567.
- Designate only one completion date for each tag in the far right column.
- The POC completion date must not exceed the latest acceptable date stated in the notice letter received with the Statement of Deficiencies.

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Acceptable PoC

Must contain the following elements with corrective actions for each tag:

- The Plan for correcting each specific deficiency
- The Procedure for implementing the PoC for each specific deficiency.
- Identify a monitoring procedure to ensure that the plan of correction is effective and that each specific deficiency remains in compliance.
- The title of the person responsible for implementing the acceptable plan of correction.
- A correction date for each tag cited.

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POC FORMAT

Surveyor:

For each requirement not met, the surveyor writes in the left column:

- The Prefix and Data Tag number
- The deficiency that contains the CFR reference and a statement that requirement is not met.
- The evidence to support the deficiency including a regulatory citation for each tag.

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POC Format

Provider:

For each tag cited, the provider writes in the middle column opposite the tag.

- The action to correct the deficiency (new policies, in-services, quality assurance, etc).
- Measures to assure no recurrence of underlying problems.
- How the corrective action will be monitored to maintain compliance and by whom.

WHO…HOW…HOW OFTEN….HOW LONG?

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What Happens after the POC is Submitted?

- The surveyor makes the determination of the appropriateness of the POC.
- If the POC is not properly completed or if there are questions about the applicability to the deficiency, the surveyor contacts the provider to obtain clarification or an appropriate modification of the Plan.
- If the POC is rejected, the surveyor seeks an acceptable POC from the Provider in writing. Changes to the POC must be modified by the provider, signed and dated, and returned to the State Agency.

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OASIS

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OASIS

- Def: requires the Secretary designate an assessment instrument that evaluates the extent to which quality and scope of services furnished by the HHA attain and (ultimately)maintain the highest functional capacity of the patient.
- OASIS State training coordinator 517-335-2086

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OASIS Tech Support

- OASIS go to QTSO.com for one stop answers to technical specifications for software interfacing.
- Access to free downloads of HAVEN software for transmitting OASIS data (also has a help desk)
- Vendor software is also permitted
- Be ready to transmit test patient assessments

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Home Health Agency

Branch Site Application Process

Deirdre Laviolette BS, RN

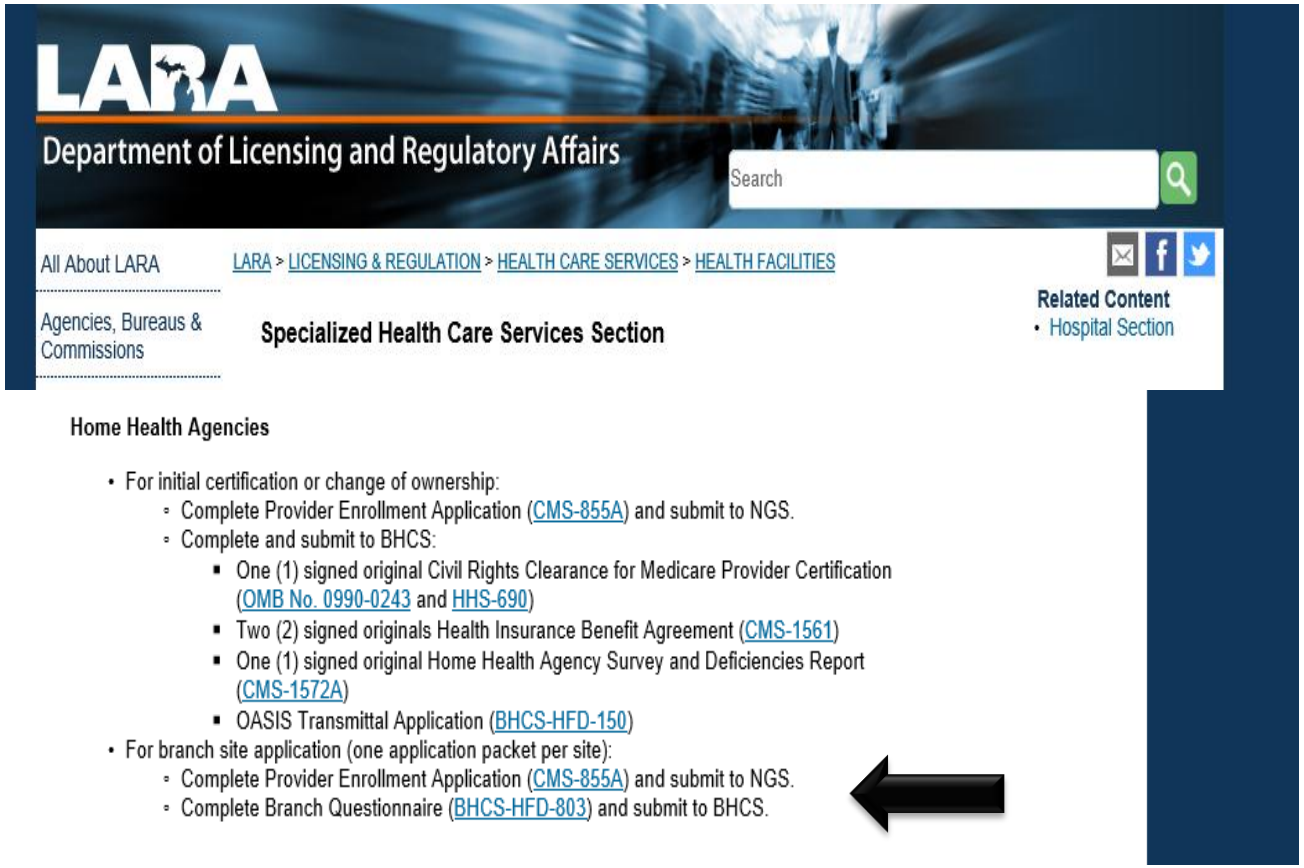
Branch Office

- Not autonomous
- Provides home health services within a portion of the geographic area served by the parent agency
- Must be physically located so that sharing of administration, supervision, and services with the branch can occur on a daily basis
- Located so that the parent is able to assure adequate supervision during all operating hours

Process:

If an existing home health agency intends to add a branch site that is going to participate in Medicare or Medicaid, you must notify in writing each of the following of the proposed location:

- Notify CMS
- Notify the State Agency
- If deemed, should notify your accrediting organization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Home Health Agencies
• For initial certification or change of ownership:
◦ Complete Provider Enrollment Application (CMS-855A) and submit to NGS.
◦ Complete and submit to BHCS:
▪ One (1) signed original Civil Rights Clearance for Medicare Provider Certification (OMB No. 0990-0243 and HHS-690)
▪ Two (2) signed originals Health Insurance Benefit Agreement (CMS-1561)
▪ One (1) signed original Home Health Agency Survey and Deficiencies Report (CMS-1572A)
▪ OASIS Transmittal Application (BHCS-HFD-150)
• For branch site application (one application packet per site):
◦ Complete Provider Enrollment Application (CMS-855A) and submit to NGS.
◦ Complete Branch Questionnaire (BHCS-HFD-803) and submit to BHCS.

Submit Form CMS-855A

- a change of information request to your Medicare Administrative Contractor…

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Submit Form BHCS-HFD-803, the Branch Questionnaire…

Including all supporting documentation

- 24 questions with multiple parts to some of the questions
- Please answer each question completely
- Clearly label each attachment….. i.e. #4, #18, etc.

BRANCH APPROVAL

- An identification number is assigned to every branch of a parent HHA.
- The identification system uniquely identifies every branch of every HHA certified to participate in the Medicare Home Health Program. It also links the parent to the branch (child).
- Having a system to identify branches gives CMS the capability of associating survey results with individual HHA branches. Also, submission of branch identification numbers on Outcome and Assessment Information Set (OASIS) assessments will provide the capability of developing outcome reports that will help HHAs differentiate and monitor the quality of care delivered by their agencies down to the branch level.
- Each branch is numbered with the same Federally assigned provider number as the parent with two modifications. There is a “Q” between the state code and four-digit provider designation plus three more digits for a 10-character branch identifier.
- The provider must obtain CMS “approval of the new branch location” before it is permitted to bill Medicare for services provided from the new location.

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Change of Ownership

- Items needed for CHOW to go forward:
  - An approved 855A (buyer)
  - A HHS- 690 form and Civil Rights packet.
  - A CMS 1561 Health Insurance Benefit Agreement
  - A CMS 1572 a Home Health Agency Survey
  - A bill of sale that identifies effective date of transfer.
  - A cover letter that identifies buyer, seller, effective dates, and/or other pertinent details of the CHOW.

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Questions & Answers

Bureau of Community and Health Systems

Ottawa Building, 1st Floor

611 W Ottawa Street

Lansing, MI 48909

Federal Certification Contact Number: (517) 241-3830

www.michigan.gov/healthfacilities

(See Licensing & Regulation/Health Care Services)

Thank you for your efforts to provide quality health care to Michigan residents.